The Pickering Report, Part VI: earnings of doctors and review of fees

By Edward Pickering

CMAJ presents the sixth and final installment of the report commissioned by the Ontario Medical Association. The $200,000 study, completed in May 1973, has attracted national attention and many of its recommendations have been accepted, not only by the OMA but by other provincial divisions. Commissioner Edward A. Pickering, a retired industrialist, was given total freedom to conduct the study as he saw fit and bring in such recommendations as he, in his sole judgement, considered appropriate.

One reads statements that doctors must curb the steady rise in the fees they charge. The fact of the matter is that there has been no increase in the schedule of fees since May 1, 1971. Whether the association should propose an increase in fees May 1, 1974, will be examined below.

Net taxable average earnings by doctors in the $30,000 or $40,000 brackets are substantial. But to avoid misrepresentation they should be placed in some perspective. We have only to look in our daily newspapers, to see what inflation has done to many traditional values; the cost of housing, for example.

When the lifetime estimated earnings of a plumber are in the order of $1 million then $1.5 million for a general practitioner may not seem too much out of line. Especially when one takes into account that the general practitioner usually puts in a work week greatly in excess of 40 hours, and is subject to working and being on call at irregular hours.

Attempts have been made to restate the earnings of physicians on an hourly basis to afford comparison with other callings. For many reasons it is impossible to do this on a strictly comparable basis. However, for what they may be worth, the results of our research are set forth in the statistical papers which accompany this study. While they cannot be taken literally, they may be taken as offering a ball park comparison.

Airline pilots work under conditions of stress but work much shorter hours than physicians. The table shows them at an hourly rate of $26.10 compared with doctors at $17.40. Based on a 50-hour week, the table shows electricians in the Toronto area at $13.35 and plumbers at $12.75.

An examination of any group of occupations over a long enough period of time shows that the differentials in earnings change as will also their rank of earnings. In 1961, for example, lawyers and notaries were the highest paid profession in Ontario and doctors and surgeons followed in the second position.

With new tax laws creating so much work for accountants it would not be surprising to see that profession move rapidly up the scale of earnings. Indeed in 1970, the last year available, this profession had the highest rate of increase, 18.5% as compared with physicians and surgeons, 8.9%.

Nothing is constant, and hard and fast conclusions should not be drawn from trends that may prove to be temporary. For example, it would be wrong to conclude that because a particular occupation is in the number one position today, its earnings should be frozen at that level.

This does not mean that we should ignore the present high levels of doctors' earnings. On the contrary they should be taken most seriously into account in considering the timing and the character of the next revision of the fee schedule.

Doctors occupy the highest average income position of the major independent professions. Statistics compiled from tax sources by the Department of National Revenue, of average net (i.e. taxable) income in Ontario in 1970, the latest year available, show:

Physicians and surgeons	**$39,112**
Lawyers and notaries	**32,733**
Dentists	**25,242**
Consulting engineers and architects	**22,220**
Accountants	**22,539**

Physicians not only had the highest average income, but had shown the highest annual rate of increase over the preceding decade:

Physicians and surgeons	**8.8%**
Lawyers and notaries	**6.8**
Dentists	**7.6**
Consulting engineers and architects	**5.8**
Accountants	**7.3**

It is quite likely that, when available, figures for 1971 will show a continued improvement in the position of the medical profession, and it is possible that the same will be true for 1972.

There is no evidence at the moment that the average income of doctors in Ontario is levelling out. Statistics over the next few months should provide the answer. It is unfortunate that there is a time lag of almost a year in the earliest OHIP figures available, and of over two years in income tax data. With the cost of physician care to the province exceeding $500 million a year, there is an imperative need for government to produce statistics on a more current basis.

An increase, if in fact there continues to be one, in the earnings of physicians, based upon the existing fees, may be caused by any one or a combination of factors: the willingness and ability of doctors to work extremely long hours and see more people; more sophistication on the part of doctors in billing OHIP; a continuing increase in demand by people for more medical care; and the growth of population. It certainly is not due to an increase in fees.

In the light of the foregoing, if doctors' incomes are in fact still rising, it would be difficult to justify a general increase in fees at this time, particularly in view of the cutback in provincial funds for education and hospitals.

Indeed an attempt to increase fees under such circumstances might result in the profession and government finding themselves on a collision course.

To determine when the earnings of

the profession have levelled off calls for more time.

The increase in doctors' earnings which followed medicare is not peculiar to Ontario but has been observed throughout the world wherever medicare has been introduced. Sooner or later, and perhaps sooner rather than later, the position will stabilize itself. Patience on the part of both the profession and government may well avoid irreparable damage to the profession and to medical services in Ontario.

The profession would do well to recognize that government itself is facing a difficult situation. It has to collect the taxes to pay the bills and to face severe criticism, not always well informed.

What I would recommend is that the Ontario Medical Association proceed as rapidly as possible, in concert with the Government of Ontario, with the setting up of the joint committee on doctors' compensation proposed earlier and with the selection of the technicians to work under its direction.

Dr. A. Peter Ruderman, the eminent professor of health administration of the school of hygiene, University of Toronto, has written for this study an extraordinarily penetrating paper on "The Economic Position of Ontario Physicians and the Relation between the Schedule of Fees and actual Income from Fee Practice". The paper accompanies this report.

The steps involved in a re-examination of the fee schedule are outlined in detail by Professor Ruderman at pages 29 to 32 of his paper.

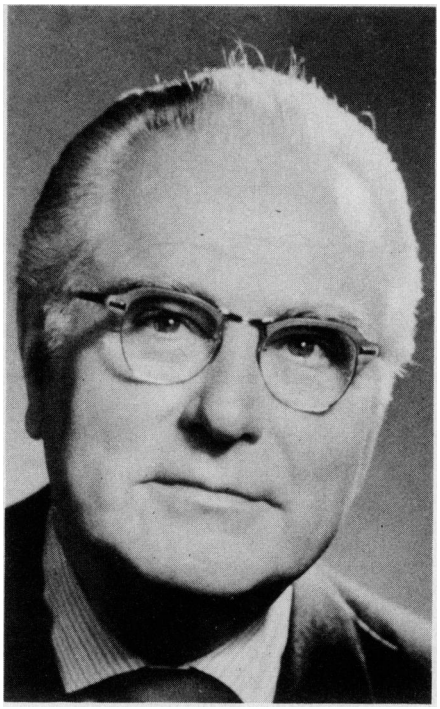
They include, first, the identification of a decline in the rate of increase of incomes which should be determined in later 1973 on the basis of 1971 (and possibly 1972) tax-derived statistics, supplemented by more timely information from OHIP for 1972-73.

Evidence of such stabilization would provide a baseline for fee negotiations.

The next step would be to determine the increase in consumer prices for the years prior to a proposed new fee schedule, the objective being to stabilize the purchasing power of physicians' earnings for 1974-75 at the 1972-73 level.

An improvement factor can be introduced at a future date by linking the fee schedule to an index of average wages and salaries or earnings of other professions; alternatively, and perhaps preferably, by establishing criteria of physician productivity rather than by tying medical fees to the earnings of any other group in society.

Even if it should prove that doctors' incomes are still rising and for that reason an across-the-board increase in fees is impolitic, the joint committee on doctors' compensation could render a necessary service by revising the schedule effective May 1, 1974, to continue the process of removing inequities between specialties, and also to remove procedures which should no longer be in the schedule.



Pickering: free to comment

Fee for service

In the public opinion survey, 66% were in favour of retaining fee for service. In the public hearings a minority point of view advocated placing doctors on salary to some degree under varying sets of circumstances.

There are, of course, other forms of compensation including capitation, basic salary with bonus features for good performance, a combination of basic salary plus fees.

In the field of compensation, it is generally the case that no single method of compensation can satisfactorily be used across the board for all personnel in any large organization. Even the most obviously appropriate method in a given set of circumstances still has its own peculiar drawbacks and defects. There is no such thing as an ideal or perfect form of compensation.

This applies to compensation arrangements in the medical field. These have been undergoing and will continue to undergo a gradual process of evolutionary change. Some clinics pay their doctors basic salary plus a bonus based on various criteria of performance. Doctors in research and administrative positions are usually paid on straight salary. Some hospitals are engaging more and more senior chiefs of service who may be paid exclusively by salary or largely by salary supplemented by fees from some private practice or teaching.

The predominant method of payment for private practice remains the fee system.

Some who argue that salary should replace fee for service would appear not to be concerned with the effectiveness of salary as a form of remuneration so much as a device for limiting the earnings of physicians. If society should reach the conclusion that doctors' earnings are too high, it would be more logical to reduce the unit fee value for procedures rather than abolish the fee system in its entirety.

It is estimated that of the total number of doctors in Ontario whether in private practice or administrative positions, between 25 and 30% are on salary in whole or in part.

The percentage has been growing and it is reasonable to expect that this trend will continue. This certainly will take place if salary arrangements currently developing in hospitals are more extensively applied and if community health centres are established.

No one can quarrel with an evolutionary process whereby changes in the way in which doctors are paid occur as the result of changes in the mode of practice and in response to specific situations and needs. This, however, is far different from an agitation to put all doctors on salary as a matter of dogma or doctrine.

Fee for service seems peculiarly well adapted to the needs of private practice, especially where the physicians concerned provide their own premises, staff, equipment, pension and other benefits. The doctor could hardly be expected to provide these out of his salary. Government then would have to provide working facilities for the vast number of physicians who today pay their own costs of doing business, which can range from 20 to 70% of gross income, out of revenues produced by fees.

It should be noted here that opposition was expressed at the hearings to there being any more involvement of government in the performance of physicians' services. Apprehension was voiced that the introduction of autocratic controls would interfere with freedom of the consumer's choice. To quote from representations made on behalf of the Consumers' Association of Canada, "the struggle for efficiency and low-cost medical care *must not* interfere with his (the patient's) choice".

A doctor on salary would expect to work a reasonable number of hours per week. He might or might not expect to be paid overtime like other workers for night work, Sundays and holidays. But it is highly unlikely that he would be willing to work consist-

ently the long hours put in by so many practising physicians today. Like salaried employees in industry and in government, he would be entitled to have pension, vacation, sickness and other benefits paid by his employer. The upshot of all this would be to involve government deeper and deeper in the mechanics and the administrative practices of medicine.

The question of what motivates professional persons and what kinds of rewards bring forth the greatest effort cannot be answered definitively. It seems likely, however, that exclusive reliance on salary would reduce some part of the motivation which doctors now have to work much longer than workers generally. This in turn would create a need for more doctors to handle an already overburdened work load.

It is highly unlikely that a universal salary system, with government provision of facilities and equipment and traditional employee benefits, combined with the increased number of doctors required, would involve less in the way of total cost than at present. There would probably be poorer service as well.

Where experience indicates that salary methods are superior in specific situations, one can be sure that they will be increasingly used. But it would be unnecessarily disruptive to create turmoil and disaffection within the ranks of the majority of practising doctors in this province by seeking to impose a salary system to serve a theoretical end.

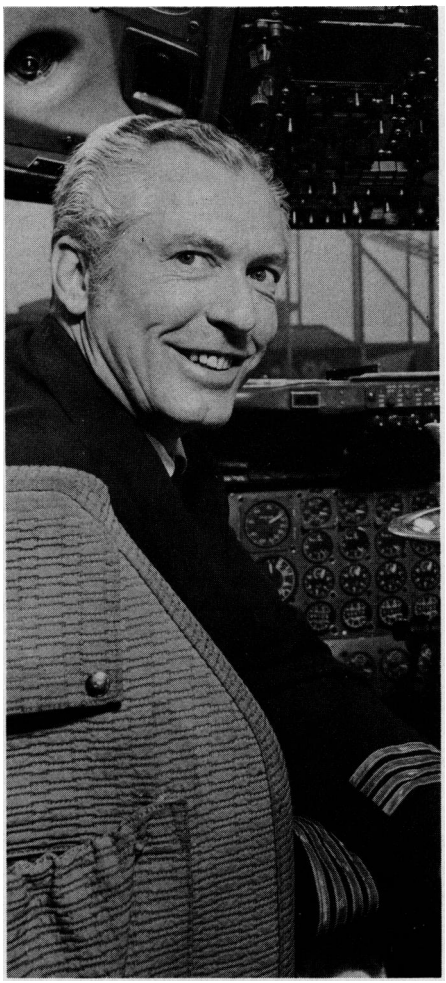
We would be further ahead to concern ourselves with deficiencies in the fee system which can be studied and corrected in an orderly way.

Non-participating physicians

The section of the OMA composed of non-participating physicians presented a brief stressing the importance of the right to join, or stay out of, a state plan. The point of view of the section is well stated in the following extract:

> There is an important place in society for the non-participating physician. The need for personalized care is dramatized by the flourishing private practices which exist, even in Communist countries. In Great Britain, over two million citizens carry private insurance for private medical care, and this is paid for in addition to the premium and taxes collected for government medical care . . . In the case of the non-participating physician, the fee is known by the patient and has to be justified by the service performed. It is the responsibility of government to encourage different methods of health care delivery, in parallel, in order to provide for as wide a range of differing needs as possible. A uniform method of health care delivery would be no more acceptable to the average person than the availability of only one design of house or car . . .
>
> The ability for participating physicians to opt out is a virtual guarantee against the unthinkable consequences of a physicians' strike in Ontario. There would be no reason for the profession to use the big weapon of the strike, if the smaller weapon of opting out is available to them!

The non-participating physician operates with all the risks normally taken by the independent professional. He relies upon his ability to satisfy his patients and to bill in a manner acceptable to them. He thus provides a means of measuring the OHIP system against the realities of the doctor-patient relationship in a free market situation.



Airline pilots receive an hourly rate more than 1½ times that of physicians.

The patient must have the right and the opportunity to choose between a doctor who participates in OHIP and one who does not. He must also be made aware in advance of any additional billing involved. Provided these safeguards are scrupulously met, the non-participating physician plays a useful part in our medical system, with participating and non-participating physicians each providing for the other a standard of comparison.

In this connection, it is pertinent to observe that the British government's recent white paper approves private practice co-existing with the National Health Service and views the presence of private, fee-paying patients in national hospitals as beneficial.

Conclusion

While a basic responsibility of the Ontario Medical Association is to advance the interests of the profession and its members, an even greater responsibility is to give leadership to the members of the profession in matters relating to the welfare of their patients and to medical and health care of the community as a whole.

If the OMA is to represent the profession effectively in determining its fee structure, it must bring to the conference table a mandate based on something more than the pecuniary interests of its members. By providing vigorous leadership in the community and service aspects of medicine, the association will gain the strongest of all mandates: the moral support of a grateful public.

The profession's best friends should be its patients and the general public. This report points out many matters with which the OMA must come to grips if it is to merit the confidence of the community at large. If the association can credibly convince the public that its guiding principle is not what is best for the profession but what is best in the public interest, it has nothing to fear.

The profession can either adapt and change to meet public need or it can wait until a growing body of public discontent forces it.

If the profession can change its character from one which is relatively closed and narrow to one which is open, cooperative and sensitive to social change, it will preserve its existence as a self-governing profession.

The profession can no longer take the position that the public is not entitled to criticize or that its criticism is necessarily unjustified and uninformed. The public today is more knowledgeable, and it does insist on the right to bring change about where it strongly feels change is required.

Like many other institutions the profession's responsibilities and scope can no longer be narrowly defined. Like other bodies it must understand and shoulder its larger social responsibilities.

I am confident that having taken the courageous and historic step of commissioning this study, the Ontario Medical Association will now translate it into an equally responsible program of action.■